To office of The clerk
of District courts clerk
matthew J. Dykman

68213
LaTHAM,
FRANK,
L.

inmate of M.H.I.C. at
Los Lunas central
N.M. CORRECTIONAL Facility,
N.M. 87031 Housing B 108

15 CV 242 MCA CG

ID
AGAIN 68213 LaTHAM, FRANK, L.
i HAVE NO money excepT
WHAT my FaTHer sends
every monTH 45^00 To Buy
my stuFF To keep clean also
WHAT Little i can Buy To
eaT. cloTHing. But i need Help
with problems with medical
such as (1) one caTHeTer for
every (4) Four Hours WHicH
is A crime in it's self
caTHeTers STATe ONE Time use
and will NOT Leave in my cell
Longer THen 30 minutes. so please
Help me some How wave THe cosT
of Filing THese legAl paper
work. i will sign any kind of
paper you wisH or ask For. over please

please excuse my spelling

To prove To you THAT im Telling you THe TruTH. just ask or send me THe paper WORK AND A post-paid envelopes like i said i dont HAVE much money and THe Facility only gives me Two (2) free ~~end~~ envelopes every oTHer week. AND i write my daddy and Little sister. so please Help me out THis medical company named CORIZON is realy making me very sick and NOT giveing me THe correct caTHeTers THAT ive Been useing sence i was 31 years old im NOW 52, for oTHer Facilitys To supplie THem AND still HAVE THe same company CORIZON HealtH service. is unreal please i Beg you Help make THe pain stop i Beg you get me THe ATTention of WHo or WHicH ATTorney ASSociations WHo Help people IN or out of prisons with or with out money. I HAVE NO WERE TO TURN. my daddy is 93 years old AND cant AFFord THe cost of an ATTorney even iF its just TO scare THis prouider IN To doing

NexT page please

IN TO doing THe RIGHT THing
and getting me my medical need
meT. THis is NOT A THreaT
BuT. iF NOT ill proBley die in Here
Because of my medical need
ive Been IN A wHeel-cHAIR For
19 years AND Been THrough many
of THem IN prisons. it TooK THem
3 monTHs just To geT THis cHAIR
Fixed so i wouldn't Fall ouT
THe Back. iAm, a diABeTic. HAve HepC.
HAve spINAL cORd injury, AND HAve
Been THe eyes of many medical
STAFF even HAving paper work
THey continue To say i caN
walk. even THeIR own doctor at
(1) ONe FAcility TesTed me AND said.
said THAT my spINAL cORd INJURY
is Real AND still THey mess with
my mind AND give me A HARD TimO
with FixING my ever own wHeel-cHAIR
AGAIN please don't LeT THe
corp's win im IN Real Need of Help
AND HAve NO way of paying For
it NOT even copy's or NOTARIzeing
paper work. copy's of medical work
will HAve TO Be goTTon THrough
court orders. AGAIN i HAve NO money

over please

with out your Help opening
The eye's of The medical company
They will just keep Hurting people
like me. and others THAT can't
STAND-ON-Their-own Two Feet
mentally ~~mentally~~ - Financialy - or Fiscally
Again like me. There are alot of
us who can't even get A Handicap
shower Here. sure They Have Handicap
Bar's But NO shower Head's To rinse
off The soap. it's realy Bad Here
And am Trying To get Back To
A medically run Facility no A place
THAT care's more about Raise in
pay. They do exist Believe me
ive seen Them But Because of
enemy List of inmate's. ive Had
To Be movie. ive Had Things THAT
No man should Have done To Him. yes
sexually Because i can defend my
self. Beaten up. stuff Taken From
me property stole. wheel-chair's Broken
it's all matter of record Throughout
The medical paper work from county
jail To The prison system's. like i said
send me any Kind of paper work i sign it
For you #68213 Frank. Latham
Frank Latham B 108
SORRY im Running out of paper N.M.C.C. Los Lunas Facility

So you can have access to my
mental and medical copy's you'll
Need - please sir Help me im also
A disABle vet NOT injured There
But also NOT IN There very Long
my mental & condition and my Fiscal condition
was just NOT There The want was But
Again The conditions of BoTH mentally and
Fiscal condition would not Let me
got out as A P.F.C. LaTHAM. FRANK 452 41 8460
South caroliwA FORT Jacksow. FORT BENNING GeorgiA
Fa Bragg. And HONORABly discHarged THen
WAS put IN A wHeel-cHAIR By A moBle Home
SeT-up IN 2/4/02 AgAIN please Help me
and otHers TO come like me. don't LeT
THe money makers off THe state get
RicH wiTH out doing THe ~~oTHe~~ RIGHT
THing except lining THere pockeTs'
off your Tax payers money And mine
FATHer's Taxes, my Family and i HAve
NO were TO TURN unless you can
Tell us or me who To write THAT will
LisTen. As you HAve THrough out THis
LeTTer THANK you - God Bless
you From all who can't
FIGHT wiTH out people like

LOCAL FORM 1

HIPAA
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
MEDICAL RECORDS

THIS DOCUMENT DOES NOT AUTHORIZE RELEASE OF ANY RECORDS CONCERNING OR RELATED TO ANY ALCOHOL, DRUG, HIV OR PSYCHIATRIC CARE, TESTING OR TREATMENT

Patient name: LaTHAM. FRANK. L **D.O.B.:** 2/24/62 **S.S.N.:** 452-41-9960

Dates of Treatment: beginning 04/8/08 **through** 3/17/15
[relevant time period must be inserted]

AUTHORIZATION:

I, FRANK, LATHAM, Frank Latham, authorize the disclosure of my protected health information as ~~described~~ herein.

1. I authorize the following person(s) and/or organization(s) to disclose the protected health information described in paragraph 3.

L.T.C.H. OF LOS LUNAS of CENTRAL N.M. CORRECTIONAL Facility. UNM Hospital of ABQ N.M.

[individual medical provider name must be inserted]

2. I authorize the following person(s) and/or organization(s) to receive the protected health information described in paragraph 3.

UNITED STATES DISTRICT COURT of NEW MEXICO. MATTHEW. J. DYKMAN. CLERK. AND DISTRICT ATTOREY also my ATTOREY'S NAMES WHICH will BE given at SIGNING of LEGAL DISCLOSER

[individual firm or lawyer must be inserted]

3. The records authorized to be released include:

all medical records and billing records including without limitation: medical reports, clinical notes, nurse=s notes, history of injury, subjective and objective complaints,

x-rays, x-ray reports or interpretations, other diagnostic tests (including a copy of the report), diagnosis and prognosis; if applicable, emergency room records or logs, history and physical examination report, laboratory reports, tissue committee reports, reports of operation, operation logs, progress notes, doctors= orders, nurse=s notes, physical therapy records, admission and discharge summaries, and all out-patient records; hospital bills, bills for the services you have rendered, bills for medication; and any other documents, records, or information in your possession relative to my past, present or future physical condition.

4. I expressly waive any laws, regulations and rules of ethics which might prevent any health care provider who has examined or treated me from disclosing my records pursuant to this Authorization.

5. The purpose of this Authorization relates to a legal action now pending in the United States District Court for the District of New Mexico.

6. I understand that I may revoke this Authorization at any time by sending a letter to the person or organization listed in paragraph one (1), except to the extent that such person(s) and/or organization(s) may have already taken action in reliance on this Authorization. If I do not sign, or if I later revoke, this Authorization, the services provided to me by such person or organization will not be affected in any way.

7. This Authorization expires one year from its date of execution.

8. THIS AUTHORIZATION DOES NOT PERMIT THE PERSON OR ORGANIZATION LISTED IN PARAGRAPH TWO (2) TO OBTAIN OR REQUEST FROM THE MEDICAL PROVIDER IDENTIFIED IN PARAGRAPH ONE (1) ORAL STATEMENTS, OPINIONS, INTERVIEWS, OR REPORTS THAT ARE NOT ALREADY IN EXISTENCE.

9. Copying costs will be borne by the person or organization named in paragraph two (2).

10. A photocopy or facsimile of this Authorization is as valid as an original.

11. I understand that a potential exists for information that is disclosed pursuant to this Authorization to be subject to re-disclosure by the recipient and therefore be no longer protected by federal confidentiality rules.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE: Frank L. Latham

CAPACITY OF REPRESENTATIVE, IF APPLICABLE: _____

DATE OF SIGNATURE: 3/17/15

LOCAL FORM 2

HIPAA
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
MENTAL HEALTH RECORDS

Patient name: LATHAM, FRANK **D.O.B.:** 2/24/63 **S.S.N.:** 452-41-9460

Dates of Treatment: beginning 04/8/08 **through** 03/16/15 THROUGH 03/17/15
[relevant time period must be inserted]

AUTHORIZATION:

I, LATHAM, FRANK. Frank Latham, authorize the disclosure of my protected health information as described herein.

1. I authorize the following person(s) and/or organization(s) to disclose the protected health information described in paragraph 3.

M.H.T.C., of LOS LUNAS of central N.M. CORRECTIONAL FACILITY.. SOUTH WEST COUNSELLING of LAS CRUCES N.M.

[individual medical provider name must be inserted]

2. I authorize the following person(s) and/or organization(s) to receive the protected health information described in paragraph 3.

UNITED STATES DISTRICT COURTS of NEW MEXICO MATTHEW. J. DYKMAN. CLERK FOR REVIEW ANY and all INFORMATION THAT PRUDENT TO THIS case, ALSO TO DISTRICT ATTOREY also my ATTORNEY'S AT SIGNING of LEGAL DISCLOSER

[individual firm or lawyer must be inserted]

3. The records authorized to be released include:

[FL] complete copy of medical records

[FL] test results

[FL] other

4. I expressly waive any laws, regulations and rules of ethics which might prevent any health care provider who has examined or treated me from disclosing my records pursuant to this Authorization.

5. The purpose of this Authorization relates to a legal action now pending in the United States District Court for the District of New Mexico.

6. I understand that I may revoke this Authorization at any time by sending a letter to the person or organization listed in paragraph one (1), except to the extent that such person(s) and/or organization(s) may have already taken action in reliance on this Authorization. If I do not sign, or if I later revoke, this Authorization, the services provided to me by such person or organization will not be affected in any way.

7. This Authorization expires one year from its date of execution.

8. THIS AUTHORIZATION DOES NOT PERMIT THE PERSON OR ORGANIZATION LISTED IN PARAGRAPH TWO (2) TO OBTAIN OR REQUEST FROM THE MEDICAL PROVIDER IDENTIFIED IN PARAGRAPH ONE (1) ORAL STATEMENTS, OPINIONS, INTERVIEWS OR REPORTS THAT ARE NOT ALREADY IN EXISTENCE.

9. Copying costs will be borne by the person or organization named in paragraph two (2).

10. A photocopy or facsimile of this Authorization is as valid as an original.

11. I understand that I have a right to examine the information to be disclosed, unless deemed that such disclosure is not in my best interest.

12. I understand that a potential exists for information that is disclosed pursuant to this Authorization to be subject to re-disclosure by the recipient and therefore be no longer protected by federal confidentiality rules.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE: Frank L. Latham

CAPACITY OF REPRESENTATIVE, IF APPLICABLE: _____

DATE OF SIGNATURE: 3/17/15

Inmate Name LaTHAM FRANK
Inmate number 68213
CNMCF/CMRU/UNIT# M.H.J.C. B108
P.O. Drawer 1328
Los Lunas, NM 87031

Legal mail

TO MATTHEW J. DYKMAN
DISTRICT COURT CLERK
SUITE 270 333 LOMAS BLVD
ALBUQUERQUE N.M
87102

RECEIVED
At Albuquerque NM
MAR 20 2015
MATTHEW J. DYKMAN
CLERK

Turn over

87102$2274

Turn over

Case 1:15-cv-00242-MCA-CG Document 1 Filed 03/20/15 Page 10 of 11

Please Read
your The only
Hope i Have